How to Bill Medicare Crossovers in ProviderOne Webinar

Frequently Asked Questions (FAQs)

Last Updated 9/22/10

Q: Can you define "Crossover" for those attendees who are new to these concepts?
A: Crossovers are claims allowed by Medicare and billed to the department as secondary.

Q: Where can I find the PowerPoint for this webinar?
A: This PowerPoint can be downloaded at:
http://hrsa.dshs.wa.gov/providerone/Webinars/MedicareCrossovers.ppt

Q: I am a nursing home provider. Do I need to enter in the Medicare information on my claims?
A: No. How Nursing Home providers bill DSHS has not changed with the implementation of ProviderOne. If you have questions on how to bill a Nursing Home claim for a Medicaid client who has Medicare you can refer to the Nursing Home billing instructions at http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Nursing_Facilities.html or you may contact the Nursing Home unit at 1-800-562-3022 ext. 16820 if you need further assistance.

Q: If Medicare does not cover the procedure, but Medicaid does, do I still need to bill Medicare first? For instance a refraction or eyeglass dispensing.
A: If Medicare NEVER covers a procedure code, you can bill it directly to the Department. If Medicare sometimes covers the service, Medicare must be billed first.

Q: If managed Medicare doesn't pay anything other than $0.01 and applied a $10 copay, will Medicaid pick that up if the patient is CNP/QMB with Medicaid?
A: We pay the lesser allowed amount of Medicare or Medicaid minus Medicare's (or the plan's) payment.

Q: Back to when we are billing for a claim that had denied and paid line items. You want two separate claims, for the denied line items; do we have to answer yes to the Medicaid crossover question or are we keying this in as if Medicaid was the primary payer only?
A: If you are billing DSHS directly for the services that Medicare denied, you do NOT answer yes to the question "Is this a Medicare Crossover Claim". It is not a crossover since Medicare did not pay. Submit the claim as a direct claim to DSHS and attach the EOMB to demonstrate non-payment from Medicare.

Q: If the patient has SLMB and is a managed Medicare patient, can we bill the patient for the copay since the program they are on with Medicaid won't pick that up?
A: Please see this memo in regards to billing a client:
http://hrsa.dshs.wa.gov/Download/Memos/2010Memos/10-25.pdf

Q: Your analogy of paying the lesser of the allowed minus Medicare's payment is confusing. What if Med C pays nothing but leaves a copay only? In more laymen's terms can you explain if that is something Medicaid would pick up since we would have received no payment.

A: Then we subtract zero from the lesser of the allowed amount. (Medicare and Medicaid's allowed amounts).

Q: Loop 2320 SBR 04 was supposed to have "Medicare" in it. If it is a Medicare Advantage plan, is it okay that it has the name of that plan? (ie. Sterling)

A: At a minimum, SBR04 would need to include the word Medicare – in your example, they could enter "Sterling Medicare Advantage," for example.

Q: I read that "electronic TPL" needs to be in the remarks field (Loop 2300 NTE Segment) for electronic claims. Is this for when primary insurance is commercial and/or Medicare? Or for commercial only? Will it mess up Medicare crossover claims if it is on those too?

A: Medicare is not TPL according to Medicaid. If you bill electronic TPL for your crossover, it will not process correctly.

Q: What happens if our HIPAA batch for Medicare Crossovers includes claims that Medicare denied?

A: Different claims can be in the same batch. You will not want them to be processed as crossovers.

Q: Is there a time the Part C info enhancement will be ready?

A: This will be a future enhancement. Sign up for our listserv so you get the latest information: https://fortress.wa.gov/dshs/hrsalistsrvsignup/ We will send out an announcement when this information is available.

Q: Is there a way to reference an original TCN when resubmitting a Medicare Part C crossover after the 6 months when submitting DDE? Or must those be billed on paper?

A: Please do not send paper. You can do a claim inquiry to locate the original denied timely TCN. You can reference that on a new claim submitted to DSHS so that it will not deny for timeliness. We encourage you to submit those crossover claims electronically.

Q: "Managed Medicare" needs to be added as a claim note on DDE crossover claims when a Medicare Advantage plan is primary. Correct?

A: If there is coinsurance, a deductible, or a NON capitated copayment due on a claim then when submitting those via Direct Data Entry, the comment "Managed Medicare" is not needed in the claims note field of the claims submission screen. It would only be required for paper claim submission.

Q: I have received many denials with code CO23. I included on the claim the amount Medicare paid. Why am I getting this denial?

A: This means that Medicare paid more than our allowable so the claim is paid in full by Medicare.

Q: We are an FQHC. Are we supposed to receive 20% of the charges from you?

A: If you bill Medicare an encounter, DSHS pays the difference between your encounter rate and what Medicare paid you. For FFS claims, we compare the Medicare payment against our allowable for the services and pay the lesser amount.

Q: My crossover claims that I billed on a UB are being denied for invalid revenue code. I billed Medicaid with the same one I billed Medicare. Why?
A: It may be a problem with the taxonomy code you are putting on your claim. I suspect you are a RH provider and need to use that taxonomy. Taxonomy drives how the system would process a claim.

Q: I thought the balance has to be 20% to all non-hospital claims?
A: That is not our payment methodology. We pay lesser of the allowed amounts minus Medicare's payment.

Q: Why don't you pay 20% for Medicare claims?
A: Because of the Balanced Budget Act of 1997.

Q: So I have to resubmit my Medicare crossover that was denied due to missing taxonomy when ProviderOne has paid us for non-crossovers fine?
A: Yes, you will have to resubmit the claim including the taxonomy code. You can use the resubmit feature of ProviderOne, add the taxonomy code, then send it to us. You would not need the EOMB with this corrected claim. You also have the option to just DDE a new claim.

Q: Example: Ankle brace for support, diagnosis is not a Medicare-covered diagnosis. Medicare denies as not a qualifying item. Can I crossover to DSHS and receive payment, or is it going to kick back stating that it is not a Medicare-covered item?
A: If Medicare denies a claim, it is not considered a crossover. We need the EOMB in this situation.

Q: We understand that the gloves or a brace would not be crossed over BUT will the claims be accepted for payment?
A: If Medicare NEVER covers the service, you can bill us directly. If Medicare sometimes covers the service, but denied your claim, we will need the denial information.

Q: Why isn't an EOMB needed when submitting a claim thru DDE? Trust? Or access to Medicare contracts?
A: We accept all of your claim information as true and valid. All claim data is subject to audit.

Q: Can we get claims for services not covered by Medicare (e.g. abortion) paid without first billing Medicare?
A: Yes, the Department recognizes some services are not covered by Medicare and if coded correctly will not stop for billing Medicare primary when you send the claim to us.

Q: When billing a Part C, do we mark that it’s a crossover?
A: Yes, if the Part C plan paid. Bill the same as a crossover. Part C is not commercial insurance

Q: Some Part C payers don't give breakdown of payment on test. Is this ok?
A: We need the breakdown for these claims.

Q: Is Medicare sending the taxonomy # when they auto forward to Medicaid?
A: Yes.

Q: We are not sending the taxonomy to Medicare. This is not mandatory by Medicare. When I spoke with Medicare's EDI department, I was told their software only accepts one taxonomy and that I would need to choose either the group or individual provider. If I only send in one, then DSHS will still deny claim for missing taxonomy. What is the best way to handle these crossovers?
A: DSHS billing requirements require that you submit both a group NPI/Taxonomy and rendering NPI/Taxonomy. If this is the case, regarding claims that crossover from Medicare to Medicaid directly, we know that Medicare will not allow you to submit both taxonomies. You will need to submit the taxonomy at the servicing or "rendering" provider level. If you are doing batch claim submission, this would be the 2310B loop (box 24j) levels, so you will need to only submit the Taxonomy at the rendering level (24j) for those claims going to Medicare first. Note that when you are submitting to Medicaid directly, you will need to submit at both levels.

Q: Does Medicare send the taxonomy they have on file on the crossover claims?
A: Medicare will forward to DSHS the taxonomy code that you put on your claim when you bill Medicare. They will only verify that the taxonomy code is a valid one not if it is the one the federal government has on file.

Q: So we do not need to put crossover on line 19 on the CMS 1500 form when it is not a true crossover?
A: Correct.

Q: When billing gloves to Medicare Part B and they are denied, do I still need to check the yes for crossover?
A: No. Do not click "Yes" on the question "Is this a Medicare Crossover Claim?" – it is not a crossover since Medicare did not pay.

Q: Does Medicaid pay on Medicare HMO's co-payment and deductable if the coverage is CNP-QMB?
A: We pay the lesser of the allowed amount minus Medicare's (or the plan's) paid amount.

Q: I was under the understanding that if the patient had Medicare Regence, for example, and the Medicaid coverage was CNP-QMB, Medicaid would not cover the service, they would only cover the premium.
A: We would pay the lesser of the allowed amounts minus Medicare's (or the plan's) payment.

Q: Are all claims still reviewed by a claims adjuster at DSHS? At this point in time, how long are you projecting that claims will take to process?
A: Some claims still need to be reviewed by an adjudicator. Most clean claims can process without human intervention.

Q: Is Managed Medicare capitated copayment the same as a spenddown program?
A: No, Managed Medicare capitated payments come from the plan; spenddown is a state program that helps determine eligibility.

Q: Do the TCN claim numbers associated with the Medicare crossovers have the Medicare EOBs already attached? For example, when we try to rebill crossovers and change the date span issue we will not have to attach the Medicare EOB??

A: We do not require the EOMB when you submit an electronic crossover.

Q: For patients, who have Medicaid tertiary, how are we able to use the DDE to bill for these copays?

A: You would check both the TPL box yes and give us the name of the insurance company and the amount they paid and then check the Medicare box yes and fill in the Medicare information. You would need to send in the commercial insurance EOB with this claim.

Q: You say that we do not need to submit an EOMB if we are submitting electronically. Is that only through ProviderOne or is that also through our own electronic clearinghouse that we do not need to submit an EOMB?

A: All electronic crossovers do not need a paper EOMB.

Q: Is it a crossover when there is a co-insurance, not just deductible?

A: Yes, it is a crossover claim if Medicare allows the service and there is only a co-insurance amount due on the claim.

Q: What if the EOMB says they forwarded to Medicaid and we check with Medicaid and they have no claim. Are we limited to the six month time frame?

A: In this case, we have extended the billing time frame to 12 months as long as the EOMB does have that message from Medicare. You may need to send the EOMB with these DDE claims to prove timeliness.

Q: If we feel a claim was denied by DSHS incorrectly, is there an online resolution dispute process instead of calling and having to be on hold for a long time?

A: You can send us an email at this link: https://fortress.wa.gov/dshs/p1contactus/. This will create a help ticket.

Q: Is there a CMS example online showing exactly what needs to be filled out for secondary claims when a Medicare Denial EOMB is being sent along with claim?

A: If Medicare denies your claim, then it is not a crossover claim and there would not be any secondary information to key on the claim. However, you would need to send the denial EOMB with your regular claim.

Q: I want to clarify your answer. If we are submitting the Medicare crossover electronically, should we be including the adjudication info?

A: We do not require the paper EOMB on an electronic crossover. Claims denied by Medicare are not considered crossovers. There are locations in the HIPAA file and the DDE screen to put the Medicare information.

Q: Once we submit a claim in DDE, how long before we would see it in process?

A: You should see the claim in ProviderOne after 15 minutes.

Q: If a provider has a taxonomy code with Medicare that was originally NOT in the list for ProviderOne (we were advised to use something "close"), I believe we are now seeing

DSHS/ProviderOne denying these for taxonomy. Whom do we contact to (a) get a taxonomy code ADDED to the option list, and (b) then correctly update the provider taxonomy in ProviderOne?

A: You are able to update your own provider file. You will need to use a taxonomy that is on your provider file. If you bill a claim with a taxonomy that is not on your provider file, your claim will deny. DSHS is only using a subset of the national taxonomy codes. For more information on taxonomy, please visit http://hrsa.dshs.wa.gov/providerone/Providers/Fact%20Sheets/P1PR009%20taxonomy.pdf

Q: If Medicare denies a claim as patient NOT being covered by Part B, for instance for medical claims, should we not be contacting your Medicare unit to update their info, making this a primary DSHS claim... versus doing DDE as a secondary payer claim?

A: You should contact the Medicare buy-in unit to have the client's file updated. For any questions regarding a client's Medicare eligibility, please contact our Medicare Buy-In Unit at 800-562-3022 ext. 16129.

Q: Can you bill a claim denied by Medicare using DDE?

A: Yes you can, but we will need the backup. Claims denied by Medicare are not crossovers.

Q: Are Part B paper claim instructions for billing DSHS crossover on the fortress.wa.gov link?

A: You can go to our new self-service publication, the *ProviderOne Billing and Resource Guide* for information at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

Q: DSHS crossover claim was denied as invalid DOB, but Medicare paid. How does this get corrected with DSHS?

A: The client needs to update their date of birth with their local Community Service Office.

Q: If a claim was submitted by direct data entry and it was a crossover and it was accidentally entered incorrectly, can it be corrected?

A: You can use the adjustment feature of ProviderOne if the claim was paid or you can use the resubmit feature and make any necessary corrections to the claim if it was denied.

Q: Taxonomy clarification: even though Medicare is crossing over the claims, you will deny all claims and we must rebill with the individual and group taxonomies?

A: If Medicare paid the claim, and you have sent Medicare one taxonomy code, then we should process the claim with that taxonomy code only.

Q: Where can I go for more information on the NDC requirements? Are they needed for paper claims when charges don't cross over but Medicare paid?

A: NDC is not required on a crossover at this time.

Q: When submitting CAH UB and we are inputting the Medicare Allowed Amount---is that the Allow/Reim that is stated on the EOMB?

A: For the institutional claims (UB-04) we want the total Medicare Allowed Amount, if your EOMB shows that amount under a "Allow/Reim" section of your EOMB, then that is what you need to enter.

Q: Since there is the 6-month period for claims submission...and DSHS is 60-90 days out on processing paper...will that be considered and not deny claims as untimely?

A: I recommend billing them electronically if they did not cross over directly from Medicare. We do stamp claims with the received date.

Q: Where on the EOMB would it state the code stating it was sent to DSHS?

A: MA07 is a remark code. Depending on how you print out the Medicare EOMB it could be in various locations. With the standard Medicare EOMB format it is with the other remark codes. "Claim information forwarded to Medicaid" also depends on the format of the printout. Standard EOMB format has it on the bottom of the claim, as a note.

Q: When submitting a UB04 crossover claim with the Medicare payment info, are we supposed to be entering it at the line item level or the payer info level of the claim attachment?

A: If you enter the claim DDE, the information is entered only at the header level, not line level. We would apply the same logic to a paper claim, header only. If you DDE the claim we don't need the EOMB.

Q: All of our claims are denying for taxonomy when crossing over from Medicare. We know our taxonomy numbers are correct due to billing directly to Medicaid. What is the problem and how do we get this fixed.

A: DSHS billing requirements require that you submit both a group NPI/Taxonomy and rendering NPI/Taxonomy. If this is the case, regarding claims that cross over from Medicare to Medicaid directly, we know that Medicare will not allow you to submit both taxonomies. You will need to submit the taxonomy at the servicing or "rendering" provider level. If you are doing batch claim submission, this would be the 2310B loop (box 24j) levels, so you will need to only submit the Taxonomy at the rendering level (24j) for those claims going to Medicare first. Note that when you are submitting to Medicaid directly, you will need to submit at both levels.

Q: Is there any way to get 92004 or 92014 vision exams paid without having to file through Medicare as if there is no medical diagnosis? Medicare never pays.

A: If the vision service is NEVER covered by Medicare, then you do not have to bill Medicare. If Medicare sometimes covers, then you are required to bill Medicare and send the denial EOMB as backup.

Q: What is the e-mail address we can use to contact customer service on crossover claim issues?

A: https://fortress.wa.gov/dshs/p1contactus/

Q: I was told by ProviderOne that if a patient has Medicare prime and I bill paper, that I do not put the prime insurance in box 9d, nor do I mark yes in 11d. Is this correct?

A: Yes, the Department does not consider Medicare an insurance company.

Q: Taxonomy question again. So if we are sending Medicare our taxonomy in loop 2310b and it is crossing over to ProviderOne, will the claim process now correctly without the group taxonomy?

A: Yes, assuming that it is a valid taxonomy that is assigned to the provider and the service billed is allowed under the taxonomy.

Q: You said the amount billed to Medicare needs to match the amount billed to DSHS....however, for Part B claims you said to put the denials on one claim and separate out claims that are paid on another?

A: We process at line level, so the lines must match, not the document.

Q: In the box indicated for Medicare covered days, do you enter 1 for a rural health claim?

A: Yes.

Q: When doing cost reports to Medicare, Medicare requires class 24s and class 29s on claims. Has this been resolved?

A: This does not affect Medicaid claims.

Q: What is the specific date in June that the crossover was operational?

A: The Department held all crossover claims until 06/06. After that date they should be crossing from Medicare.

Q: Medicare states taxonomy codes are being transmitted on our claims to provider one, yet you continue to say the info is missing.

A: If the taxonomy code you are sending Medicare and they are sending to DSHS is not on your provider file or loaded in ProviderOne the only denial reason we could give you is that it is missing, incomplete, or invalid

Q: If claims crossover directly from Medicare and Medicaid is paying in full not just the coinsurance amount, what do we have to do? We are getting over paid.

A: Professional crossovers pay as follows:
The Medicare paid amount is subtracted from the Medicare allowed or the DSHS allowed, whichever is less.
We don't really "pay the coinsurance" ("coinsurance isn't even part of the equation we use), we pay the lesser of the allowed amounts minus Medicare paid.
There are exceptions to the rule but I think we can leave them out of scope.
You can send specific claim examples to the department by using this online form~
https://fortress.wa.gov/dshs/p1contactus/

Q: can you please explain in a different way capitated vs. noncapitated?

A: Capitated is an agreement with the payer to accept a monthly per diem rate, no FFS codes. Noncapitated means the provider bills Medicare with FFS codes and Medicare pays only for the codes billed no per diem rate.

Q: Does DSHS even cover managed care copays?

A: The Department only covers the capitated copays

Q: With regard to claim format, does that mean that if I bill Medicare electronically but bill DSHS secondary on paper, the claim will deny?

A: What we are meaning by format is the claim type. If you submit a CMS1500 electronic claim to Medicare you will want to make sure that the claim that comes to DSHS is also a CMS1500 claim, either electronically or paper. Same as with the UB04 claim forms.

Q: We have a Dr's office that accepts Medicare but no longer takes Medicaid patients. How do we

bill the Medicaid balance?

A: You have to be a contracted provider with DSHS in order to bill Medicaid. You can be contracted with Medicaid and only take as many patients as you want.

Q: If it is only a managed care copay and not payable by DSHS do we need to bill it to DSHS?

A: No, not required to bill DSHS. The patient is not responsible either.

Q: When considering payment for a Medicare C crossover, do you consider the total billed amount or by CPT code?

A: The system adjudicates crossovers by line level CPT codes.

Q: I have billed my Medicare Part C crossovers as insurance not Medicare. Will these claims be denied? Should I resubmit them now or wait for a denial

A: Yes, they will be denied. If the claims are still in process wait until denied before rebilling as crossovers.

Q: If a patient has QMB coverage and Medicare does not cover the service can we bill the patient? If so would the patient have had to sign a waiver?

A: Please refer to the billing the client memo number 10-25. We had an internal workgroup that has updated this policy. Please find this memo at http://hrsa.dshs.wa.gov/Download/Memos/Year2010.html